

# EXHIBIT U



ReliaStar Life Insurance Company  
ING Customer Service Center  
P.O. Box 5044 Minot, ND 58702

June 30, 2014

Trang Vu  
9226 Sandstone St  
Houston TX 77036-6042

RE: Owner: Trang Vu

Policy # AD20029262

Insured(s): Tuyet Tran

Dear Trang Vu:

Thank you for your interest in reinstating your policy. To begin the reinstatement process, please complete the enclosed application for reinstatement and return it to the ING Customer Service Center. A checklist is included to help you complete the application correctly. After reviewing your application, we will let you know our decision or if additional information is needed.

We appreciate the trust you've placed in the ING family of companies to help you meet your financial objectives. If you have any questions, please contact your agent, registered representative or the ING Customer Service Center during our business hours of Monday – Friday, 8 a.m. to 6 p.m. Central time.

Sincerely,

ING Customer Service Center

Questions? Call (800) 654-5375

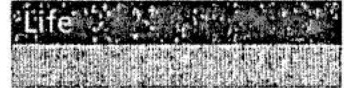
Fax (877) 788-6314

877-788-3151

Insurance products are issued by ReliaStar Life Insurance Company, a member of the ING family of companies.

Please see attachment -  
Completed and signed Reinstatement  
app.

Thanks,  
Trang



# APPLICATION FOR POLICY CHANGE OR REINSTATEMENT WITH EVIDENCE OF INSURABILITY

- ☒ ReliaStar Life Insurance Company  
☐ Security Life of Denver Insurance Company  
☐ ING USA Annuity and Life Insurance Company  
☐ Midwestern United Life Insurance Company



Members of the ING family of companies  
 ("the Company")

ING Customer Service Center: PO Box 5011, Minot, ND, 58702-5011

## PART I - A. REQUEST FOR CHANGE (Policy Number is required for all requests. Select appropriate request type and provide details.)

1. Policy Number AD20029262  
 2. ☒ REINSTATEMENT REQUEST (No other policy changes are permitted for reinstatement requests.)

a. If there is a Children's Insurance Rider on your existing policy, complete the chart below for each child.

Child Full Name	Gender	Birth Date	Birth State	Height & Weight	SSN	Relationship to Primary Insured	Amount of Life Insurance In Force	Date of Most Recent Life Insurance Purchase

## 3. ☐ POLICY CHANGE REQUEST (Complete appropriate details in question a. - g. below.)

- a. Increase or Decrease Base Face Amount from \$ \_\_\_\_\_ to \$ \_\_\_\_\_  
 b. Premium Class Change from \_\_\_\_\_ to \_\_\_\_\_  
 c. Change in Premium Amount \$ \_\_\_\_\_  
 d. Subsequent Premium Payment Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly (Available with electronic funds transfer.)  
 e. Removal of a Rider \_\_\_\_\_  
 f. Addition of a Rider \_\_\_\_\_ Amount \$ \_\_\_\_\_  
 If adding a Children's Insurance Rider, complete the Children's Individual Insurance Rider Application.  
 g. Other Insured Rider Information

Other Insured Name	Gender	Birth Date	Birth State	SSN	Relationship to Primary Insured	Amount of Life Insurance In Force	Date of Most Recent Life Insurance Purchase

4. Other Requests/Instructions N/A.

## PART I - B. PRIMARY INSURED INFORMATION

1. First Name TUYET MI N Last Name TRAN  
 2. Birth Date REDACTED SSN REDACTED Birth State/Country Vietnam Gender: ☐ M ☒ F  
 3. Residence Address (PO Boxes are not permitted.) 9226 Sandstone St.  
 City Houston State TX ZIP 77036



**PART I - B. PRIMARY INSURED INFORMATION** (Continued)

4. Daytime Phone (713) 992-6864 Evening Phone (713) 480-5228
5. Best Time to Call Anytime E-mail TRANGHOUSTON@Live.Com
6. Are you a U.S. Citizen? (If "No," complete the Foreign Travel and Residence Questionnaire.) ☐ Yes ☒ No
7. Occupation/Duties Beauty Supply and Service
8. Do you currently use or have you ever used tobacco or nicotine products in any form? (e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches). ☐ Yes ☒ No
- If "Yes," indicate Type \_\_\_\_\_ Amount & Frequency \_\_\_\_\_ Month/Year Last Used \_\_\_\_\_
9. Driver's License Number REDACTED 10. Driver's License State TX  
(If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)
11. Name on Driver's License (if different than above) Same as above.

**PART I - C. OTHER INSURED INFORMATION** (Complete this section only if applicable.)

1. First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_
2. Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Birth State/Country \_\_\_\_\_ Gender: ☐ M ☐ F
3. Residence Address (PO Boxes are not permitted.) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
4. Daytime Phone (\_\_\_\_\_) \_\_\_\_\_ Evening Phone (\_\_\_\_\_) \_\_\_\_\_
5. Best Time to Call \_\_\_\_\_ E-mail \_\_\_\_\_
6. Are you a U.S. Citizen? (If "No," complete the Foreign Travel and Residence Questionnaire.) ☐ Yes ☐ No
7. Occupation/Duties \_\_\_\_\_
8. Do you currently use or have you ever used tobacco or nicotine products in any form? (e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches). ☐ Yes ☐ No
- If "Yes," indicate Type \_\_\_\_\_ Amount & Frequency \_\_\_\_\_ Month/Year Last Used \_\_\_\_\_
9. Driver's License Number \_\_\_\_\_ 10. Driver's License State \_\_\_\_\_  
(If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)
11. Name on Driver's License (if different than above) \_\_\_\_\_

**PART I - D. OWNER/TRUST/CORPORATION INFORMATION**

1. Full Name of Owner/Trust/Corporation (30 character limit) TRANG KHANH VU
2. Owner Phone (713) 992-6864 Owner SSN/TIN REDACTED
3. Owner Address (PO Boxes are not permitted.) 9226 Sandstone St.  
City Houston State TX ZIP 77036

**PART I - E. PERSONAL HISTORY** (Questions 1-7 must be completed for all insureds age 16 and up.)

- |   | Primary Insured   | Other Insured  |
|---|---|--|
| 1. Are you, or have you entered into a written agreement to become a member of the armed forces, including the Reserves? (If "Yes," complete the Military Questionnaire.)   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Do you intend to travel or reside outside the United States or Canada in the next two years? (If "Yes," complete the Foreign Travel and Residence Questionnaire.)  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you in the last five years made or do you anticipate in the next two years making flights in an aircraft OTHER than as a passenger on a scheduled airline? (If "Yes," complete the Aviation Questionnaire.)                       | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, or rodeos? (If "Yes," complete the appropriate questionnaire.)                                       | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes or dune buggies? (If "Yes," complete Avocations and Professional Sports Questionnaire.) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |



**PART I - E. PERSONAL HISTORY (Continued)**

6. Except for traffic violations, have you been convicted in a criminal proceeding or been the subject of a pending criminal proceeding? Primary Insured: ☐ Yes ☒ No Other Insured: ☐ Yes ☐ No
7. Have you in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle? Primary Insured: ☐ Yes ☒ No Other Insured: ☐ Yes ☐ No

For any "Yes" answer to questions 6-7, please record information in the chart below.

Question	Insured/Other Insured	Explanation

**PART I - F. FINANCIAL DETAILS**

1. Is the policy in accordance with your insurance objectives and your anticipated financial needs? ☒ Yes ☐ No
2. Do you believe you have the financial ability to continue making premium payments on this policy? ☒ Yes ☐ No
3. Have you or your company ever declared bankruptcy? (If "Yes," provide details, type and date discharged.) ☐ Yes ☒ No

4.	Annual Earned Income	Annual Interest and Other Income	Total Assets	Total Liabilities	Total Net Worth
Primary Insured	\$ 40,000	\$ $\phi$	\$ $\phi$	\$ $\phi$	\$ $\phi$
Other Insured	\$	\$	\$	\$	\$

**PART I - G. IN FORCE/REPLACEMENT INFORMATION (Questions 1-3 must be completed for each Insured/Other Insured/Proposed Insureds.)**

1. Do you currently have life insurance in force or applied for? (If "Yes", provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.) Primary Insured: Yes ☐ No ☒ Other Insured: Yes ☐ No ☐

Insured Name	Insurance Company (Do not include group policies.)	Policy Number	Amount	Date Issued

2. Are you considering using funds from your existing policies or contracts to pay premiums due on this policy or contract? (If "Yes", complete state required replacement form and provide details below.) Primary Insured: Yes ☐ No ☒ Other Insured: Yes ☐ No ☐
3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? (If "Yes", complete state required replacement form and provide details below.) Primary Insured: Yes ☐ No ☒ Other Insured: Yes ☐ No ☐
4. For any "Yes" answer to questions 2-3, provide details regarding the policies being replaced in the chart below.

Insured Name	Insurance Company	Policy Number	Amount



**PART I - H. NOTES** (Use this space to provide any additional details to questions answered throughout the application. Please understand that if you provide the Company with information on this page it will be considered part of your Application for Policy Change or Reinstatement with Evidence of Insurability. If you need additional space, please attach a separate piece of paper to the application.)

Section	Question	Details

### PART I - I. ING'S POLICY ON STRANGER-OWNED OR STRANGER-ORIGINATED LIFE INSURANCE (STOLI)

The Company, along with other ING Life Companies strongly opposes arrangements designed to obtain life insurance for the benefit of a third party (a "stranger") that has no insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. We believe this position supports the best interests of our policy owners, as stranger-owned or stranger-originated life insurance transactions ("STOLI") will lead to higher costs for consumers and undermine the concept of insurable interest, a core element of the life insurance business. The Company will seek to terminate the insurance coverage under any contract determined to be STOLI or where material misrepresentation has occurred regarding the facts presented to the Company for underwriting the application. Attempts to defraud the Company may result in additional legal action.

The Company does not sell life insurance in the following circumstance:

- If, at the time of sale or conversion, the applicant/owner has an intent, plan, arrangement or understanding with a third party that will result directly or indirectly in the sale, assignment, settlement or other transfer to an investor, such as a life settlement company, or any other party with no insurable interest in the life of the insured who purchases the policy for investment purposes;
- If, at the time of sale or conversion, the applicant/owner has an intent, plan or arrangement to transfer an ownership interest or beneficial interest in an entity that will own the policy to a life settlement company or any other party with no insurable interest in the life of the insured;

- If, in connection with the sale, the applicant/owner and/or the insured is offered any compensation, reward or benefit, or other inducement to purchase or assist in the purchase the policy, including, but not limited to, cash payments, property such as a life insurance death benefit for "free" or at "no cost" or any other benefit of any kind;
- Where a sales concept, design, marketing plan, marketing material or other program that has not been disclosed to the Company is used in connection with the sale (including, but not limited to, any nontraditional premium finance program, such as "non-recourse" lending arrangement where the lender's sole collateral for the premium loan is limited to the values of the policy itself);
- Where the producer and/or applicant knows, or has reason to know, that the source of funds for premium payments under a policy has not been disclosed to the Company (including, but not limited to, any arrangement to pay for premiums under the policy through a loan through a premium financing arrangement or other third party funding); or
- In any other circumstance determined by the Company, in its sole discretion, to be inconsistent with our policies on STOLI, insurable interest or misrepresentation.

The activities described above are considered "prohibited conduct".

### PART I - J. AUTHORIZATION AND ACKNOWLEDGEMENT

**Incontestability.** If the policy change, conversion, or addition requires new evidence of insurability, the policy date for the purpose of the incontestability and suicide provisions shall be the date of this application. Where no new evidence is required, the policy date of the original policy will be the policy date for the purposes of the incontestability and suicide provisions. If the policy is reinstated, the policy date for the purpose of incontestability shall be the date of this application.

**Verification.** By signing this form, I acknowledge that I have read this application and I agree with the statements in this application and declare that all questions have been truthfully answered to the best of my knowledge and belief. The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully. This application consists of all pages of the Application, appendices, and supplemental questionnaires. It will be the basis for any policy change or reinstatement approved and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein. The producer does not have the authority—unless permitted by law—to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or

requirements. No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing. I understand that by signing this application, I am applying for life insurance coverage issued by the Company.

No new insurance or policy change requested above (including a reinstatement) shall be in force until: (a) any required payment for the request is paid in full, and (b) the request is approved by the Company while the facts and health condition of those to be insured remain the same as represented in this application. Even if the Company accepts payment made with this application, it may decline the request. The Company may require additional evidence of insurability before approving this request.

**By my signature on the next page, I affirmatively warrant and represent that I have not engaged in any prohibited conduct described in Section I above in connection with this application for insurance.**

**Statements of Understanding.** I understand that this authorization will be valid for 24 months from the date of signature on this application. I have the right to receive a copy of this authorization, and a photocopy will



**PART I - J. AUTHORIZATION AND ACKNOWLEDGEMENT (Continued)**

be as valid as the original. I give my permission to the Company and other insurance companies affiliated with the company to collect medical record information and consumer or investigative consumer reports about me and my minor children for the purposes described in this application. I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me and any minor children who are to be insured. I give my permission to the Company to send any information obtained to MIB, Inc., reinsurers, the producer who solicited my application and his or her principals, employees or contractors who process transactions regarding insurance coverage for which I have applied.

I acknowledge receipt of the following disclosures and notices: Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices. I certify, under penalty of perjury, that my Social Security Number/tax identification number is shown and is correct and that I am not subject to back-up withholding.

If an investigative consumer report is prepared, I request to be interviewed. ☐ Yes (If "No," leave the checkbox blank.)

Interview Information: Daytime phone number: ( ) \_\_\_\_\_

Contact me between the hours of \_\_\_\_\_ a.m./p.m. and \_\_\_\_\_ a.m./p.m.

**By signing below I acknowledge and agree that any policy issued in relation to this application (the "Policy") shall be subject to the following Governing Law and Jurisdiction provisions:**

**Governing Law.** The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.

**Jurisdiction.** Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

**All completed materials must be sent to the ING Customer Service Center at: 2000 21st Ave. NW, Minot, ND 58703**

This application will be attached to and become part of the policy.

**I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.**

Owner Signed at (city/state) Houston, TX Date July 10, 2014

Owner Signature (if other than the Insured) Trang Vu Trang Vu

Owner/Trustee Name (Please print.) TRANG VU.

Insured Signature (if age 15 or older) X [Signature] Date 07/14/2014

Other Insured Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
(if the Owner, Primary Insured or the Other Insured is a minor)

Assignee Name (Please print.) \_\_\_\_\_

Assignee Signature (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

**By signing below I acknowledge that I have not engaged in prohibited conduct as described in Section I, "ING's Policy on Stranger-Owned or Stranger-Originated Life Insurance (STOLI)," nor am I aware of such conduct by the applicant.**

Writing Agent/Registered Rep. Signature \_\_\_\_\_ Date \_\_\_\_\_

Writing Agent State Lic. Number \_\_\_\_\_ Writing Agent/Registered Rep. Number \_\_\_\_\_

Agent/Registered Rep. Name \_\_\_\_\_

Agent State Lic. Number \_\_\_\_\_ Agent/Registered Rep. Number \_\_\_\_\_

**ING CUSTOMER SERVICE CENTER USE ONLY**

Endorsed by \_\_\_\_\_ Date \_\_\_\_\_ Effective Date \_\_\_\_\_



## PROOF OF DEATH - CLAIMANT'S STATEMENT

ReliaStar Life Insurance Company, Minneapolis, MN  
 ReliaStar Life Insurance Company of New York, Woodbury, NY  
 Security Life of Denver Insurance Company, Denver, CO  
 Midwestern United Life Insurance Company, Fort Wayne, IN  
 Voya Insurance and Annuity Company, Des Moines, IA  
 Members of the Voya® family of companies  
 (the "Company")



Voya Life Claims: PO Box 1548, Minneapolis, MN 55440

Voya Life Claims Overnight Mailing Address: 20 Washington Ave. South, Minneapolis, MN 55401

Phone: 888-238-4840; Fax: 855-653-5339; Submit at voya.com (select Contact & Services > Claims > Upload a Claim)

### CLAIM CHECKLIST

- ☒ SIGN and DATE this completed form, then submit using one of the above methods.  
☒ Attach a certified death certificate and any other required documentation. **Missing or incomplete information may delay claim processing.**

### SECTION 1. GROUP OR POLICY INFORMATION

Group or Association Name <sup>1</sup> (If applicable) \_\_\_\_\_

Group or Association Policy Number <sup>1</sup> \_\_\_\_\_ OR Insurance Policy Number(s) AD20029262

<sup>1</sup> Group or Association Name and Group or Association Policy Number apply ONLY if coverage was obtained through an Employer or Association.

### SECTION 2. INSURED INFORMATION

Primary Insured Name (First) TUYET (Middle Initial) N. (Last) TRAN

Birth Date REDACTED SSN REDACTED Gender: ☐ Male ☒ Female

Other names the Primary Insured may have been known by N/A.

Address 10910 Gold Point Dr #1106 City Houston State TX ZIP 77064

Marital Status: ☒ Married ☐ Domestic Partner / Civil Union ☐ Never Married ☐ Divorced ☐ Widowed

### SECTION 3. DECEASED INFORMATION

The Deceased Is: ☒ The Primary Insured ☐ Spouse of Primary Insured ☐ Child of Primary Insured ☐ Other \_\_\_\_\_

Deceased Name, if not Primary Insured (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

Cause of Death murdered in robbery SSN REDACTED Gender: ☐ Male ☒ Female

Birth Date REDACTED Death Date July 20, 2015 Country Where Death Occurred Harris

Address at Time of Death 10800 Bellaire Blvd #1D City Houston State TX ZIP 77072

If death was caused by injuries, explain (Attach newspaper clipping, if available.) beating

### SECTION 4. BENEFICIARY INFORMATION (The beneficiary name should be shown exactly as it is listed on the policy beneficiary designation. If the beneficiary's name has changed, documentation of the name change must be submitted with this form.)

Beneficiary Name (Individual, Trust, Estate, or Entity) Trang Vu

Relationship to Deceased: ☒ Spouse ☐ Domestic Partner ☐ Child ☐ Trustee ☐ Estate Administrator ☐ Other \_\_\_\_\_

If Relationship is "Trustee" on what date was the Trust created? \_\_\_\_\_

Birth Date REDACTED SSN / TIN <sup>2</sup> REDACTED Gender: ☒ Male ☐ Female

Phone (713) 9926864 Email Trang.Houston@live.com

Address 10910 Gold Point Dr. #1106 City Houston State TX ZIP 77064

Mailing Address (if different from above) same City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

<sup>2</sup> Enter Social Security Number if beneficiary is an individual or Taxpayer ID Number if a trust, estate, or entity.



**SECTION 5. PREFERRED PAYMENT METHOD**

Select from the most common payment options below. For details of all options available to you, refer to the insurance policy or contact us.

- ☒ **Lump Sum Check.** Your entire benefit will be settled as a check made payable to you. You will not earn interest after the check is issued.
- ☐ **Proceeds Held At Interest.** Your benefit will be held by the Company while earning interest at a declared rate credited annually. The declared rate may be subject to a guaranteed minimum specified in the policy. You can make withdrawals in amounts of \$100 or more by contacting us.
- ☐ **Installment options.** Your benefit will be paid to you in installments over time while earning interest. If you choose an installment option, please contact us and we will assist you in structuring your installment payments. The enclosed document, "Your Payment Options as a Life Insurance Beneficiary", provides further details.

**INTEREST PAYABLE ON INDIVIDUAL LIFE INSURANCE POLICIES ISSUED IN ILLINOIS:** As provided by Illinois insurance law, if payment is not made within 31 days from the date we receive due proof of death, interest at the rate of 10% from the date of death to the date of our payment will be included with the death benefit.

**SECTION 6. US TAXPAYER CERTIFICATIONS** *(Signature required.)*

Under penalties of perjury, I certify that:

1. The Taxpayer Identification Number that appears on this form is correct,
2. I am not subject to backup withholding due to failure to report interest and dividend income<sup>3</sup>, and
3. I am a U.S. person

<sup>3</sup> If you are subject to back-up withholding, you must strike through statement number 2.

**NON-RESIDENT ALIEN STATUS**

If you are a Non-Resident Alien, please check the box and provide your country of residence below.

☐ Under penalties of perjury, I certify that I am a Non-Resident Alien and my country of residence is: \_\_\_\_\_.

The amount paid to you will be subject to 30% withholding, unless you submit an IRS Form W-8, and are entitled to claim a reduced rate of withholding under the applicable US tax treaty.

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

By typing your name in the box below, you are electronically signing this document. Your electronic signature will be legally binding and enforceable and the legal equivalent of your handwritten signature.

➞ Beneficiary Authorized Signature T. R. R. Date Oct 22, 2015.

POLICY NUMBER	AD20029262	POLICY DATE	August 28, 2008
INSURED	Tuyet Tran	FACE AMOUNT	275,000.00
ISSUE AGE	41 Female	PREMIUM INTERVAL	Quarterly
		PREMIUM CLASS	Super Pref No Tbco
INITIAL PREMIUM	\$83.94		
ISSUE DATE	August 22, 2008	EXPIRY DATE	August 28, 2062

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**IMPORTANT - READ YOUR POLICY CAREFULLY**

This is a legal contract between you and ReliaStar Life Insurance Company. This contract is called a Policy. The word "you" means the Policy Owner. The application shows the name of the Policy Owner. The word "we" means the ReliaStar Life Insurance Company. We promise to pay the Death Benefit to the Beneficiary subject to the provisions of this Policy. See "Payments By Us," for description of the Death Benefit. The Beneficiary is the party that you name. We will pay the Death Benefit when we receive proof of death of the Insured. The Policy Data Page shows the name of the Insured. Age at any time is the Issue Age shown on the Policy Data Page increased by the number of policy years completed. For information or service on this Policy, contact the person who sold you this Policy, or any of our offices including our Home Office.

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**NOTICE - RIGHT TO CANCEL**

**You have a right to return this Policy. Read it carefully. If you do not want this Policy, you may deliver or mail it to the person who sold it to you or to any of our offices including our Home Office. You must do this by the twentieth day after you receive this Policy. If this Policy is a replacement Policy as defined by state law where this Policy is delivered, you have the right to examine and return this Policy within 30 days after you receive it. All payments made for this Policy will be returned to you within ten days after the returned Policy is received at the Home Office or Administrative Office.**

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**RELIASTAR LIFE INSURANCE COMPANY**

A Stock Company

**Home Office:**

20 Washington Ave South  
PO Box 20  
Minneapolis, MN 55440

**Administrative Office:**

2000 21st Ave NW  
Minot, ND 58703-0890

Executed at our Home Office.

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Secretary

---

President

**INDETERMINATE PREMIUM TERM LIFE INSURANCE POLICY TO AGE 95  
WITH EXCHANGE OPTIONS AND PREMIUM ADJUSTMENT PROVISION  
NON-PARTICIPATING**

**POLICY SUMMARY**

This is a Non-Participating Indeterminate Premium Term Life Insurance Policy to Age 95 with Exchange Options and a Premium Adjustment provision. The Face Amount remains unchanged as long as the Policy is in force. Premiums are payable to age 95, or until the Insured's death, whichever comes first. During the Initial Term Period, premiums are level and are based on the plan elected by you at the time of application. After the Initial Term Period, premiums may increase but will never be greater than those shown in the Schedule of Maximum Premium by Year.





ReliaStar Life Insurance Company  
ING Customer Service Center  
PO Box 5044 Minot, ND 58702

March 11, 2009

Tuyet Tran  
19822 Hidden Shadow Lane  
Cypress TX 77433

RE: Owner: Tuyet Tran

Policy #: AD20029262

Insured(s): Tuyet Tran

Dear Mr. Tran:

As requested, the current beneficiary designation for your policy, effective 03/02/2009, is listed below:

Primary Beneficiary: Trang K Vu 100%.

Contingent Beneficiary: F [REDACTED] T [REDACTED] 50%, D [REDACTED] T [REDACTED] 50%.

Third Contingent Beneficiary: Lang Thi Dam and Lien Tran

Please keep this letter with your policy as confirmation of the change in beneficiary.

We appreciate the trust you've placed in the ING family of companies to help you meet your financial objectives. If you have any questions, please contact your agent, registered representative or the ING Customer Service Center during our business hours of Monday – Friday, 8:00 a.m. to 6:00 p.m. CST.

Sincerely,

Virginia Gross  
Client Change Coordinator

Questions? Call: 800-654-5375  
Fax: 877-788-6308

Insurance products are issued by ReliaStar Life Insurance Company, a member of the ING family of companies.



ReliaStar Life Insurance Company  
ING Customer Service Center  
P.O. Box 5011 Minot, ND 58702

August 22, 2014

Trang Vu  
9226 Sandstone St  
Houston TX 77036

RE: Owner: Trang Vu

Policy # AD20029262

Insured(s): Tuyet Tran

Dear Trang Vu:

We're pleased to inform you that your application for reinstatement has been approved. We've applied your payment of \$139.90 to your policy, and your coverage is now active with premiums paid to 11/28/2014. A refund of \$111.92 will be sent under separate cover.

Enclosed is a copy of the endorsed reinstatement application, which you should include with your important records.

We appreciate the trust you've placed in the ING family of companies to help you meet your financial objectives. You can review your policy online at [www.ingservicecenter.com](http://www.ingservicecenter.com). If you have further questions about your policy, contact your agent, registered representative or the ING Service Center during our business hours, Monday - Friday, 8 a.m. to 6 p.m. Central time.

Sincerely,

ING Life Customer Service

Enclosure: Endorsed Reinstatement Application

cc: LIFE QUOTES INC

Questions? Call (877) 886-5050 Fax (877) 788-6305

Insurance products are issued by ReliaStar Life Insurance Company, a member of the ING family of companies.

10006 1/5/2007

RETIREMENT

INSURANCE

INVESTMENTS

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